STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005107	A. BUILDING: _____ B. WING _____	09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00137191 Substantiated: Deficiency cited related to allegations. Date: 9/16/14 Facility Number: 005107 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor QA: claughlin 10/07/14	S 000		
S 930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and personnel interview, nursing staff failed to supervise and evaluate the nursing care for each patient related to lack of daily bathing and lack of documentation of peri-care for 1 of 5 (N1) closed patient medical records reviewed. Findings:	S 930		

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S 930	Continued From page 1 1. Policy titled "Perineal Care", revised/reapproved 2/20/13, was reviewed on 9/16/14 at approximately 4:00 PM, and indicated on pg. 1, under: a. Key Points section, point 1., "Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and, if necessary, at bedtime and episodes of incontinence." b. Documentation section, point 1., "Document in the patient's electronic medical record." 2. Review of closed patient medical records on 9/16/14 at approximately 11:20 AM confirmed patient N1 was an 84-year-old who was admitted to the facility on 8/13/13 for aortic valve replacement: A. per Nurses Notes and Daily Care Flowsheets dated 8/14/13 through 8/22/13: a. bathing and oral care was provided to patient daily, except for 8/15/14 which had no documentation related to bathing. b. lack of peri-care documentation on 8/15/13, 8/16/13 and 8/17/13. 3. Personnel P6, Director of Nursing Operations, was interviewed on 9/16/14 at approximately 12:26 PM and confirmed: A. documentation of bathing was lacking for 8/15/13 and for peri-care on 8/15/13, 8/16/13 and 8/17/13. Peri-care is provided during daily bath, but is not always documented in the daily bath charting area. It is protocol to do peri-care with the daily bath. Facility policy and procedure were not followed related to daily bathing and peri-care.	S 930		